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RADV Audits of MA Plans Put Providers on The Spot; 'Not All Diagnoses' Are in One Place

Although they're moving slower than expected, CMS risk adjustment data validation (RADV) audits of Medicare Advantage (MA) plans are under way and will ripple down to providers that treat MA enrollees. Depending on what it finds in the way of errors and overpayments, CMS is expected to clawback money from MA plans, which may do the same to providers, especially if their coding and documentation breaks cardinal rules in connection with hierarchical condition categories (HCCs).

"Everything starts and stops with provider documentation," said Kristy Evans, a principal at PYA. Because of that, providers and MA plans have a shared "risk environment," Evans said at an April 22 webinar sponsored by the firm. Some MA plan contracts with providers allow them to recoup payments that aren't supported by documentation or are otherwise flawed.

Future of Extrapolation is Hazy

CMS announced plans in May last year for a slew of RADV audits.[1] They're proceeding as planned but are a bit behind schedule, said Valerie Rock, a principal at PYA. According to a January 2026 memo, CMS selects a sample of 35 to 200 MA claims to audit, which requires providers to produce medical records that would presumably support the claim. CMS accepts a maximum of two medical records to support each HCC.

"They're auditing every plan" for payment years 2018 to 2024, said Bob Paskowski, a principal at PYA. CMS is expected to eventually extrapolate MA overpayments, putting more downward pressure on providers. Although last year a federal court struck down a 2023 regulation empowering CMS to extrapolate MA overpayments, CMS has appealed the decision. It also could go back to the drawing board and publish a new rule that overcomes the court's procedural objections.

Compliance Landmines in Higher RAF

Even though they focus on MA plans, RADV audits are a concern for providers because their diagnoses and treatment drive risk adjustment, which is at the heart of CMS reimbursement to MA plans. CMS pays MA plans based on HCCs, which are based on ICD-10 diagnosis codes from face-to-face encounters with a provider in an approved place (e.g., office, inpatient or outpatient setting).

"Think of risk adjustment as a prospective look at what claims will look like into the future," Paskowski said. "It's predictive based on prior claims, age and gender" and care resources that will be consumed in the future. CMS builds a risk profile for every MA enrollee based on this data, which, along with Star ratings and geography, determines the amount CMS pays MA plans per month, per enrollee. In turn, MA plans reimburse providers for services provided to enrollees on a fee-for-service basis or capitation in risk-based contracts. HCCs are used to calculate the capitation payment.

Although providers submit diagnosis codes, not medical records, to MA plans for billing purposes, MA plans may review medical records to ensure accuracy, Paskowski said. There are compliance landmines in the connection between a

higher risk adjustment factor (RAF) score and the number of diagnoses reported, although only one diagnosis per category is used to calculate the RAF score.

Reporting of HCCs is held to a different standard than evaluation and management (E/M) coding, Rock said. The guidelines for ICD-10 reporting and the guidelines that drive level section in E/M codes don't match. That gets confusing because MA plans may reimburse providers based on E/M codes with a fee-for-service method. During a review of provider coding and documentation, "you wouldn't say, 'We are removing these HCC diagnoses on this side so it's an automatic change to the E/M level,'" Rock explained. "If a diagnosis reported on a claim is determined to be unsupported, the E/M level reported and reimbursed isn't necessarily affected."

Not All Diagnoses Are in One Place

When providers are audited by MA plans or internally review HCC compliance, they should keep in mind that not all diagnoses may be supported in their own records, Rock said. "Just because you're submitting claims doesn't mean you're the only one serving that patient." Suppose a primary care physician submits a heart failure diagnosis to the MA plan, but it's not supported in their records for the patient. "It could be supported along the continuum of the patient," Rock said. The MA plan is only obliged to support an HCC once for the reporting year for CMS purposes. There's no harm to CMS.

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"This adds to the complexity of a provider determining contractual obligations of ICD-10 errors with an MA payer," Rock noted.

Accurate diagnosis code reporting backed by documentation supports the HCCs. They only incorporate diagnoses that are being actively assessed or managed by the provider. Providers may use the coding and documentation standard known as MEAT—monitor, evaluate, assess and treat a condition—although documentation of only one is adequate, Evans noted. For example, if a patient has a history of an acute myocardial infarction (MI) or stroke, it wouldn't count toward the HCC if it's not managed in the current encounter.

HRA Must Link to All Other Conditions

A lot rides on the problem list, which is the list of active or chronic medical conditions and diagnoses. The problem with the problem list is that historical conditions may be pulled through electronic medical record (EMR) templates to subsequent encounters. "You tend to have acute conditions in the problem list that are no longer relevant," Evans said. For example, sepsis may keep making an appearance even though the sepsis infection cleared years earlier. Other diagnoses at high risk for inappropriate reporting are acute MI, cancer, acute cerebral vascular accidents and embolism, among other diagnoses, Evans said. "You have to look at documentation to see if the condition is still acute or is historical."

Things may get sticky with the health risk assessment (HRA), which is a questionnaire required in the Medicare Annual Wellness Visit. HRAs are supposed to include chronic conditions that affect patient management, "but chronic conditions may only be coded on the claim if documented, and the documentation has to tie into how the chronic condition affects medical decision making of the patient visit," Evans said. In other words, the HRA must link to all other conditions being treated. Even when patients see the physician for a simple complaint, their underlying conditions may influence the physician's medical decision making, she explained. Documentation of that thought process—"the overall clinical picture"—should tie back to that.

In terms of the ICD-10 coding impact on the RAF score, diagnoses must be coded to the highest specificity, Rock and Evans said. "Everything goes back to the completeness and specificity of the documentation," Evans noted. If the documentation of an encounter includes diabetes generically, but previous visits show the patient had complications of diabetes, the code selection can only rely on the unspecified diabetes for the current date of service. "You can't go back and you've got to have specificity in that note."

Common Problems With Coding and Documentation

To support HCCs, documentation must include certain elements, Evans said. They include the patient's name and date of service and the provider's name and credentials on every page of the medical record. Also, patient encounters must be face-to-face with the physician and conditions documented clearly and concisely (see box below).[2]

Evans cited common errors with risk adjustment coding and documentation:

- **Providers code and document a history of the condition as if it were active.** For example, it's a red flag for an auditor if they see acute MI on a regular outpatient office visit. "Unless the patient had an MI in the office that day, it's very rare for acute MI to be coded on a follow-up office visit," she noted.
- **There's a discrepancy between what's billed and what's documented in the EMR.** For example, unspecified chronic kidney disease (CKD) doesn't risk adjust, but CKD stage 4 does. If CKD stage 4 was billed, physicians must have that extra piece of documentation to support it. "That's where the specificity of the physician's documentation comes into play," Evans said.
- **Providers may tend to only report the first principal diagnosis, not all diagnoses, that require treatment.** "They need to add all chronic conditions" that factored into medical decision making, she said. Ideally, documentation includes the main reason for the visit; co-existing acute conditions; chronic conditions; care provided; and conclusion/diagnoses.

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Endnotes

1 Centers for Medicare & Medicaid Services, "CMS Rolls Out Aggressive Strategy to Enhance and Accelerate Medicare Advantage Audits," news release, May 21, 2025, https://bit.ly/3HeAplf.

2 Nina Youngstrom, "Checklist for Auditors to Review Support for HCC Administrative Components," *Report on Medicare Compliance* 35, no. 16 (April 27, 2026).

Checklist for Auditors to Review Support for HCC Administrative Components

Here's a tool to help providers ensure the presence of documentation for the administrative components that support hierarchical condition categories, which are at the heart of Medicare Advantage (MA) plan reimbursement. CMS is now auditing MA plans en masse, and their findings may trickle down to providers in the form of overpayment recoupment (see story, p. 1).[1] The checklist was developed by Kristy Evans, a principal at PYA. Contact Evans at kevans@pyapc.com.

Administrative Guidelines

☐ **Face-to-face visit**

☐ **Appropriate provider type**
- ✓ MD
- ✓ DO
- ✓ PA
- ✓ NP
- ✓ DPM
- ✓ DC
- ✓ OD
- ✓ CNS
- ✓ Nurse-midwives
- ✓ Independently practicing PT's

☐ **Appropriate location**
- ✓ Inpatient hospital stays longer than 24 hrs
- ✓ Outpatient hospital services
- ✓ Provider practice

☐ **Inappropriate location**
- ✓ Clinical lab
- ✓ Diagnostic radiology
- ✓ SNF
- ✓ Hospice
- ✓ Ambulance
- ✓ Free-standing dialysis centers
- ✓ Free-standing ambulatory service centers
- ✓ DME/Prosthetics/Orthotics

☐ **Appropriate signature, including credentials and date**

☐ **Condition impacts medical decision making**

☐ **Evidence of monitoring, evaluation or treatment**

Endnotes

1 Nina Youngstrom, "RADV Audits of MA Plans Put Providers on The Spot; 'Not All Diagnoses' Are in One Place," *Report on Medicare Compliance* 35, no. 15 (April 27, 2026).